

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8424		88404	
1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown Rural Oraville c. LENGTH OF STAY IN 1b 3 hrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital	
3. NAME OF DECEASED (Type or print) Dawn First Brigette Middle		Last Buckler	4. DATE OF DEATH Month Day Year July 3, 1960
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 27, 1960	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Howard Allen Buckler		14. MOTHER'S MAIDEN NAME Doris Jean Posey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 154-44-1234 17. INFORMANT Hospital Records	
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) endocardial fibroelastosis (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Jen (County) Calvert (State) Md	
21. I certify that (I) (this hospital) attended the deceased from Jan. 1960 to June 1960 that (I) (we) last saw the deceased alive on July 11, 1960 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE <i>Leon D. Barbee</i>		22b. DATE SIGNED July 1960	
22c. PHYSICIAN'S NAME (Type) Leon Barbee Leon D. Barbee M. D.		22d. ADDRESS Mechanicsville Leonardtown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/5/60 23c. NAME OF CEMETERY OR CREMATORIAL St. Joseph & 23d. LOCATION (City, town, or county) Morganza, (State) Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland		ADDRESS 2078254X18	
		25a. REC'D BY REGISTRAR DATE JUL 6 '60 25b. REGISTRAR'S SIGNATURE Arthur S. Jones	

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8432 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08405

TO DELIVER MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If at any time it is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 12 hours after death.

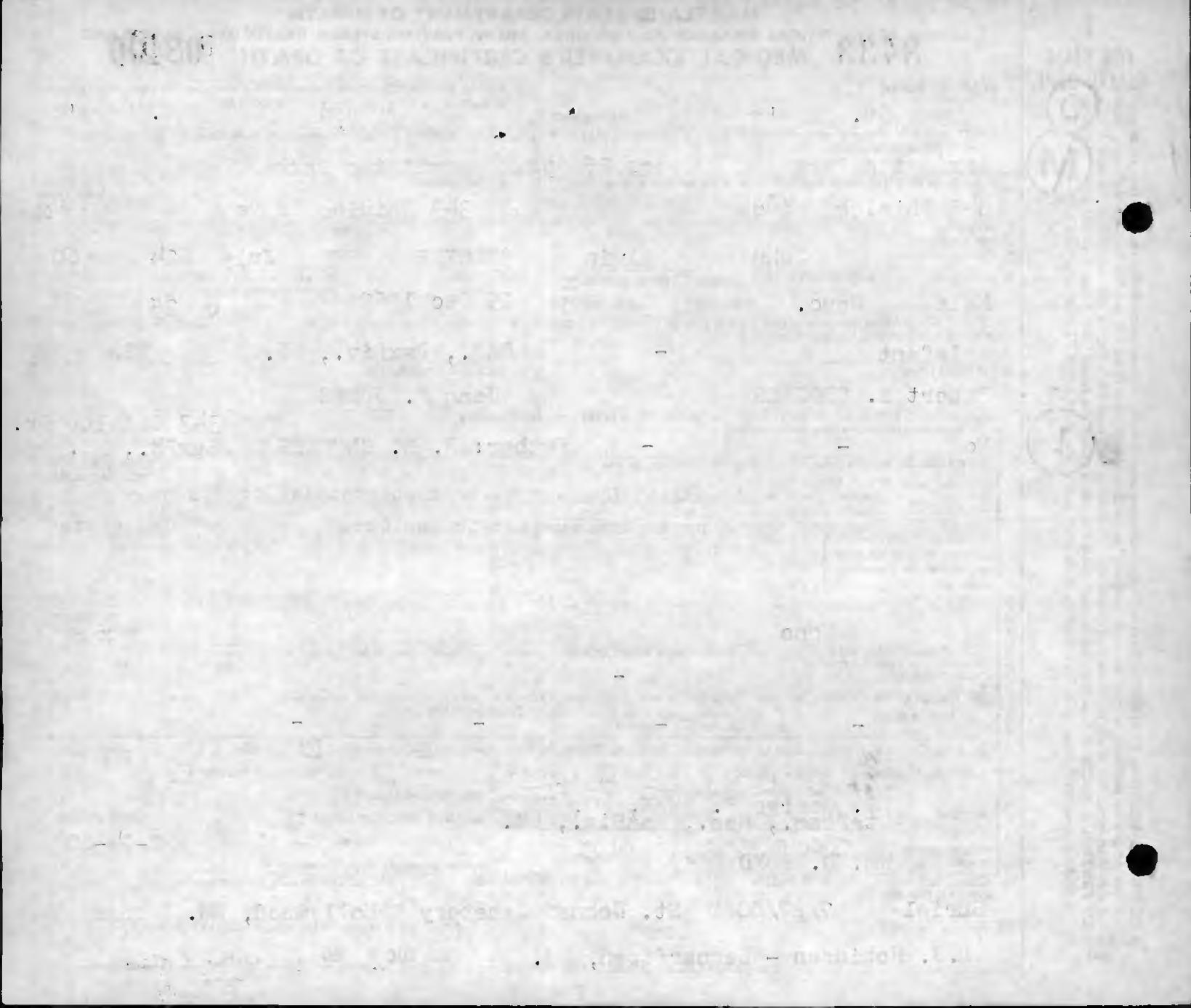
PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hollywood		c. LENGTH OF STAY IN lb Life		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's			
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hollywood					
						d. STREET ADDRESS X		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles Manley		First Charles	Middle Manley	Last Clarke Jr.	4. DATE OF DEATH July 23, 1960	Month July	Day 23	Year 1960			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 12, 1957	9. AGE (In years last birthday) 3 yrs.	IF UNDER 1 YEAR Months 3	Days 0	IF UNDER 24 HRS. Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
				Maryland		U.S.A.					
13. FATHER'S NAME Charles Manley Clarke		14. MOTHER'S MAIDEN NAME Jean Marie Edwards									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Charles M. Clarke Hollywood, Maryland		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning		DUE TO 929.8									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell off wod at Clark's Landing		20c. TIME OF INJURY Month, Day, Year Hour 7-23-1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> at Clark's Landing		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hollywood		20f. (City or town) (County) (State) Hollywood 41 May. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> MD Boyd									
ACTUAL SIGNATURE MD Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D.									
EXAMINER'S NAME (Type) William D. Boyd M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Hollywood, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/25/60		22c. NAME OF CEMETERY OR CREMATORIAL St. John's		22d. LOCATION (City, town, or country) Hollywood, Maryland		(State)			
23. FUNERAL DIRECTOR W. Clarke Mattingley Leonardtown, Maryland		ADDRESS		24a. REC'D BY REGISTRAR JUL 26 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Moore					

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE MARYLAND
8433 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 0840E1 FOR STATE
HEALTH DEPT.

TO DEFENDY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Mary's		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lexington Park		c. LENGTH OF STAY IN 1b 6 mos 25 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 343 Chinlee Drive		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lexington Park	
3. NAME OF DECEASED (Type or print) John Elwin		d. STREET ADDRESS 343 Chinlee Drive	
3. NAME OF DECEASED (Type or print) John Elwin		4. DATE OF DEATH CROCKER	Month July
5. SEX Male		Day 24	Year 1960
6. COLOR OR RACE Cauc.		6. COLOR OR RACE NEVER MARRIED	7. MARRIED <input type="checkbox"/>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (State or foreign country) NAS., PaxRiv., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert E. CROCKER		14. MOTHER'S MAIDEN NAME Jean F. JONES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. - - -	
17. INFORMANT - - -		Address 343 Chinlee Dr. LexPk., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIATION, due to tracheobronchial occlusion 922.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) by aspirated gastric contents (c) Immediate		INTERVAL BETWEEN ONSET AND DEATH - - -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) - - -	
20c. TIME OF INJURY Hour a.m. p.m. - - - 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N
20f. (City or town) S. N.		(County) S. N.	
(State) Md.		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> <i>George R. Swan</i> ACTUAL SIGNATURE LTC George R. SWAN, MC, USNR EXAMINER'S NAME (Type) Wm. D. BOYD MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 7-24-60		Address (Street, city, town, or county) Hollywood, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/27/60	22c. NAME OF CEMETERY OR CREMATORIAL St. Johns Cemetery
22d. LOCATION (City, town, or country) Hollywood, Md.		(State) Md.	
23. FUNERAL DIRECTOR ADDRESS P.B. Robinson & Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE AUG 3 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>



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MARYLAND STATE DEPARTMENT OF HEALTH

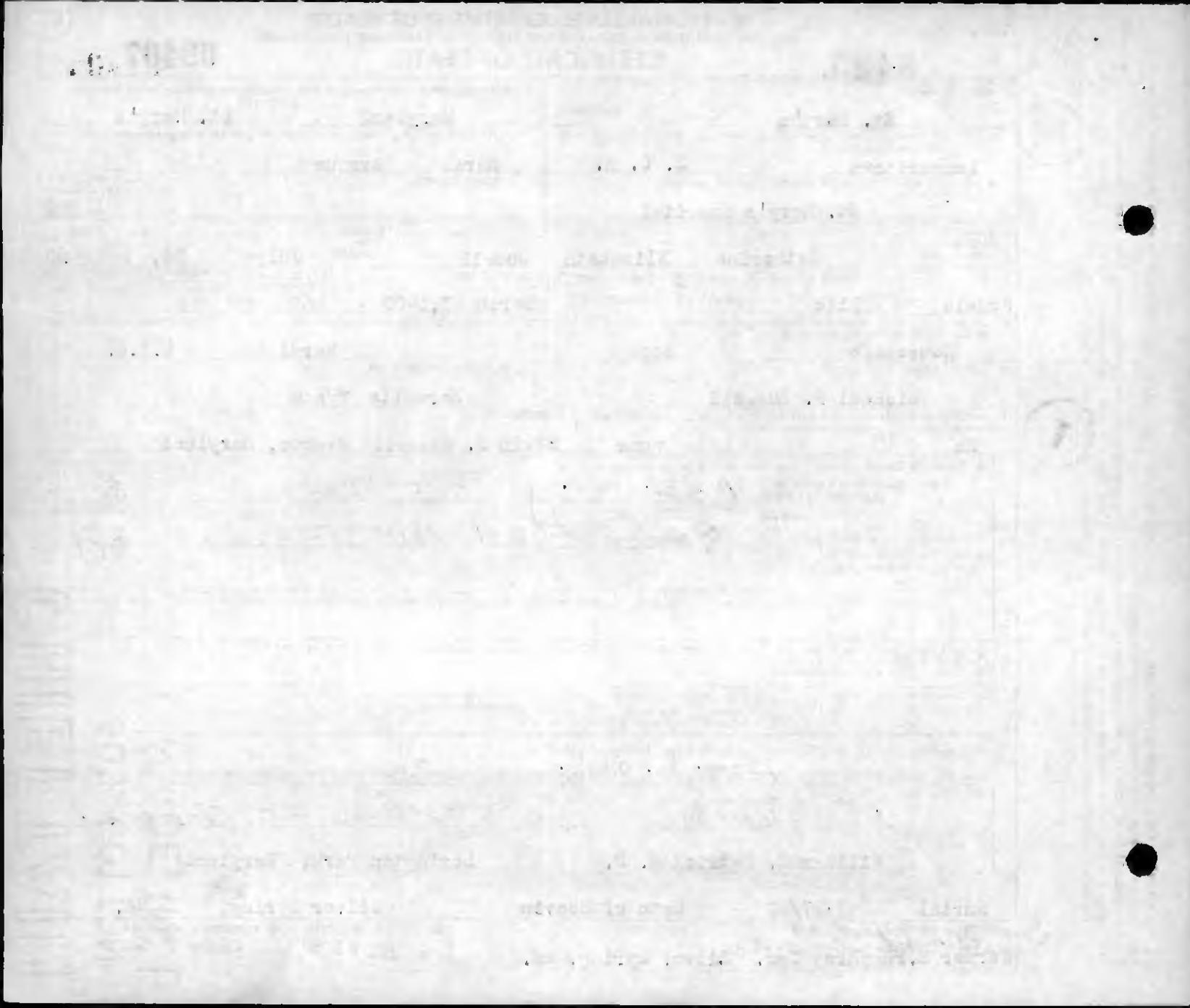
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8425

08407

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
St. Mary's		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b D. O. A.	
d. NAME OF HOSPITAL (If not in hospital, give street address) St. Mary's Hospital		X Rural Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
Katharine Elizabeth Duvall		July 24, 1960	
5. SEX		6. COLOR OR RACE	
Female		White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/>		March 17, 1900	
DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Michael F. Russell		14. MOTHER'S MAIDEN NAME Marcella Tyson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
No		none	
17. INFORMANT		Address	
Edwin B. Russell Avenue, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary thrombosis 36 min.	
420.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Generalized Arteriosclerosis 6 yrs.	
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (II) (we) last saw the deceased alive on _____, and that death occurred at _____ PM, from the causes and on the date stated above.			
22a. SIGNATURE <i>W.H. Patrick</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) William H. Patrick M. D.		22d. ADDRESS Lexington Park, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/27/60	
23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven		23d. LOCATION (City, town, or county) (State) Silver Spring, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey Inc.</i>		ADDRESS	
		25a. REC'D BY REGISTRAR DATE JUL 28 '60	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



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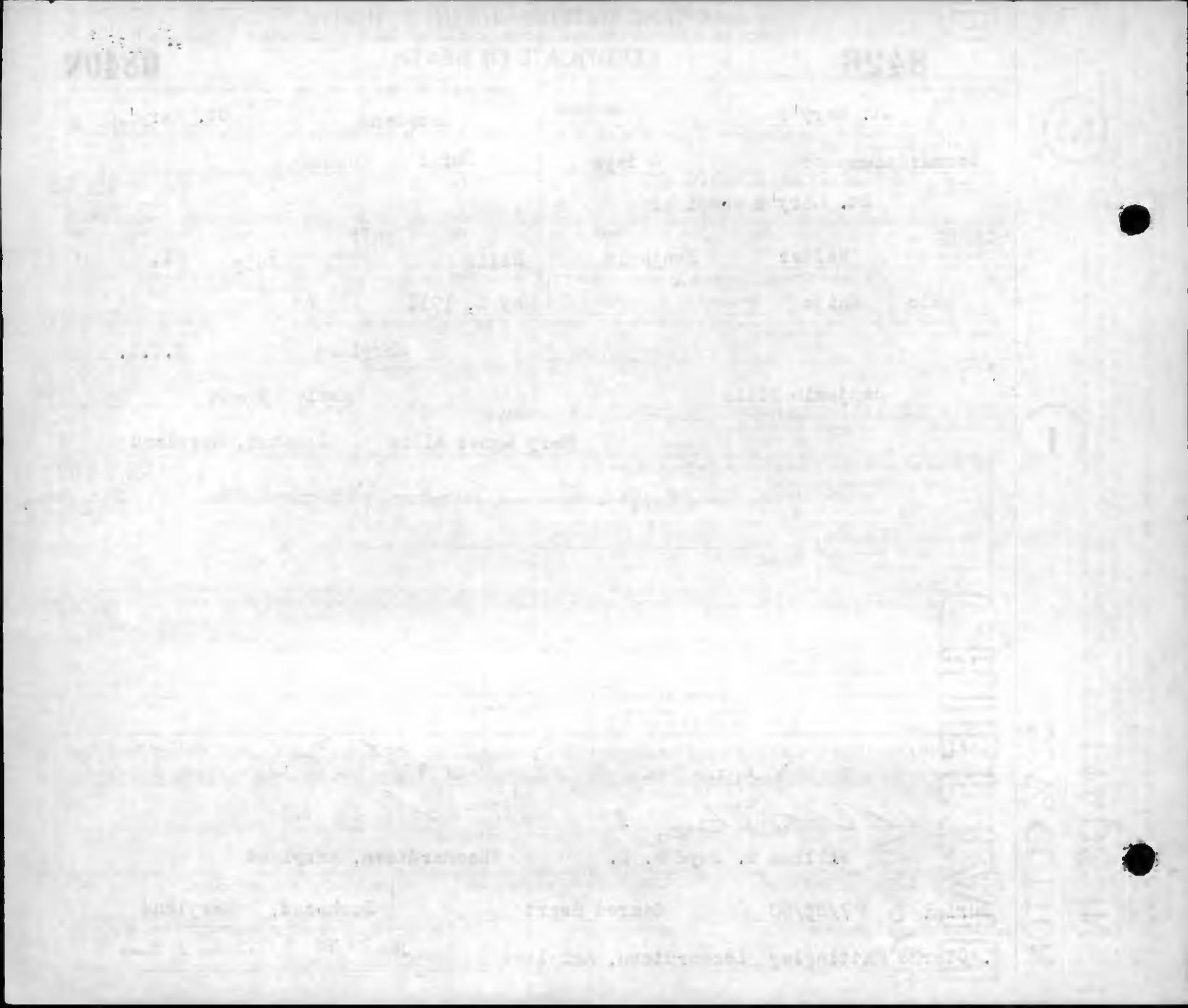
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08408

8426

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Compton				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Walter	Middle Benjamin	Last Ellis	4. DATE OF DEATH July 21, 1960	Month July	Day 21	Year 1960
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 1, 1911	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
				Maryland		U.S.A.		
13. FATHER'S NAME Benjamin Ellis		14. MOTHER'S MAIDEN NAME Annie Knott						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mary Agnes Ellis		Address Compton, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Hypertension Cardiac Vascular Disease</i> 5 yrs						
443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO						
{ (b)		DUE TO						
{ (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from June 1958 to July 21, 1960 , that (I) (we) last saw the deceased alive on July 20, 1960 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.								
22a. SIGNATURE <i>W. D. Boyd</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) William D. Boyd M. D.		22d. ADDRESS Leonardtown, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/23/60		23c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart		23d. LOCATION (City, town, or county) (State) Bushwood, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. Clarke Mattingley</i>		ADDRESS Leonardtown, Maryland		25a. REC'D BY REGISTRAR DATE JUL 25 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08409

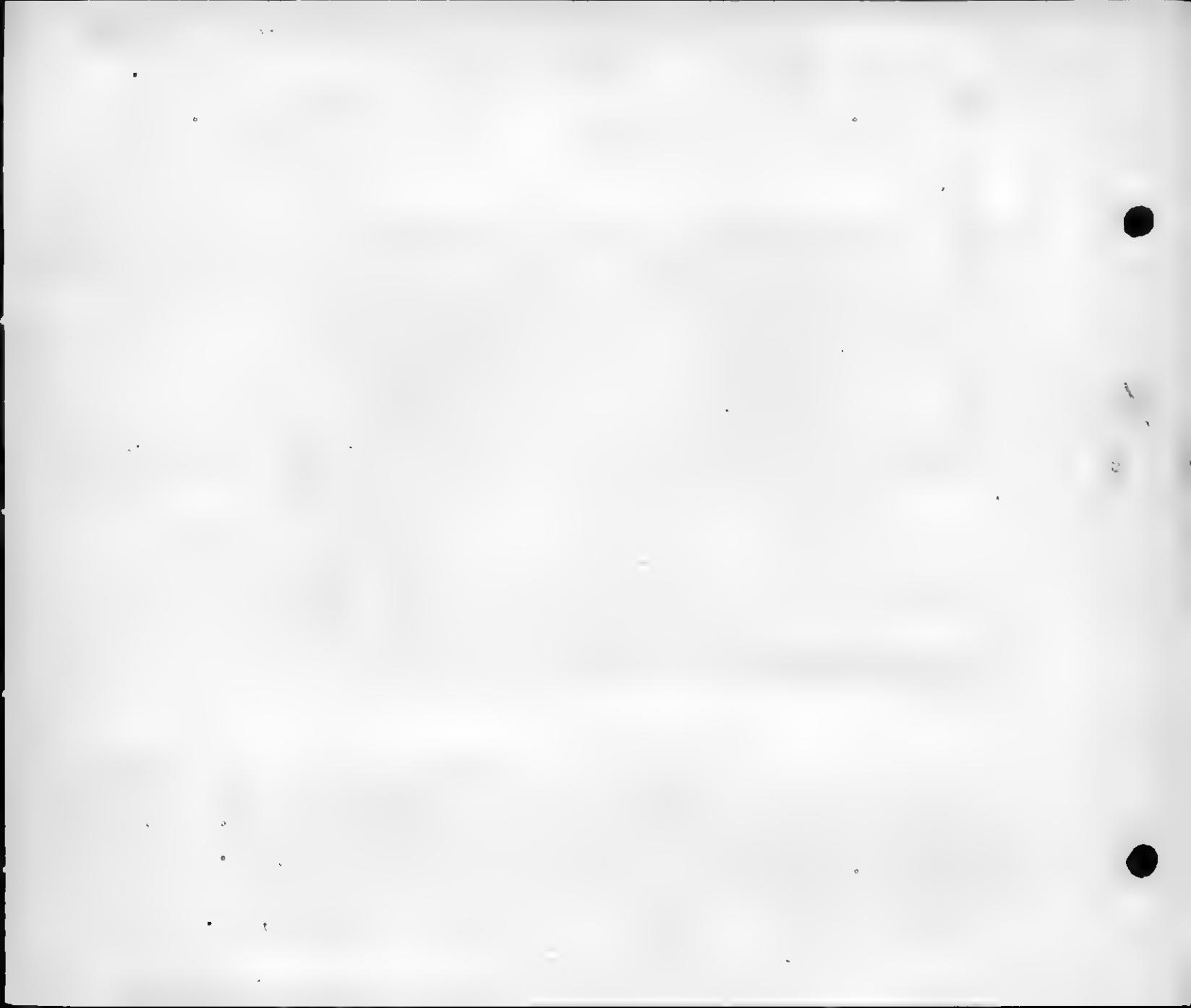
CERTIFICATE OF DEATH

Reg. Dist. No.

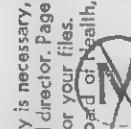
M		8434		CERTIFICATE OF DEATH				
1. PLACE OF DEATH a. COUNTY St. Marys		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY St. Marys		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville		c. LENGTH OF STAY IN 1b Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville		d. STREET ADDRESS Rural		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Pearl Love Fowler		First	Middle	Lost	4. DATE OF DEATH July 28	Month	Day	Year
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 12/9/1883	9. AGE (In years last birthday) 76 yr	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Philip Love		14. MOTHER'S MAIDEN NAME Ada Holmes						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. -- -- - - -		17. INFORMANT John A. Fowler - Mechanicsville, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO Hyperensive cardiovascular dis 10 yrs		Cardiac decompensation		INTERVAL BETWEEN ONSET AND DEATH 1 week		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Mechanicsville, Md.		(County)		(State)
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>48</u> , to <u>July 28</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>July 28, 1960</u> , and that death occurred at <u>Mechanicsville, Md.</u> from the causes and on the date stated above.								
ACTUAL SIGNATURE J. Roy Guyther				ADDRESS Mechanicsville, Md.		DATE SIGNED 7/29/60		
PHYSICIAN'S NAME (Type) J. Roy Guyther, MD								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/1/60		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Suitland, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson, Leonardtown, Md.		ADDRESS		24a. REC'D BY REGISTRAR AUG 3 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72-hours after death.



1
FOR STATE
HEALTH DEPT.



TO DELIVER MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending". In pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8435 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08410

1. PLACE OF DEATH

e. COUNTY

St. Mary's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Hollywood

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First

Middle

Henry

5. SEX

6. COLOR OR RACE

Male

Colored

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

June 10, 1925

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Clerk

10b. KIND OF BUSINESS OR INDUSTRY

Civil Service

11. BIRTHPLACE (State or foreign country)

Edgewater, N. J.

13. FATHER'S NAME

Edgar Gary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and date of service)

es

H.W. 2

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

825 X
Conditions, if any which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Crushing chest injuries

INTERVAL BETWEEN
ONSET AND DEATH

10 min

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

and accident

19. WAS AUTOPSY
PERFORMED?

YES NO

20c. TIME OF INJURY Month, Day, Year
Hour o.m.

7-24-60

20d. INJURY OCCURRED While Not While
at work at work

Aug 135

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) County (State)
Hollywood St. Mary Md

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

EXAMINER'S
NAME (Type) William D. Boyd M.D.

ASSISTANT MEDICAL EXAMINER

M.D.

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED

7-24-60

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORI

22d. LOCATION (City, town, or county)

(State)

Burial 7/28/60

Arlington National

Cemetery Arlington

Va.

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

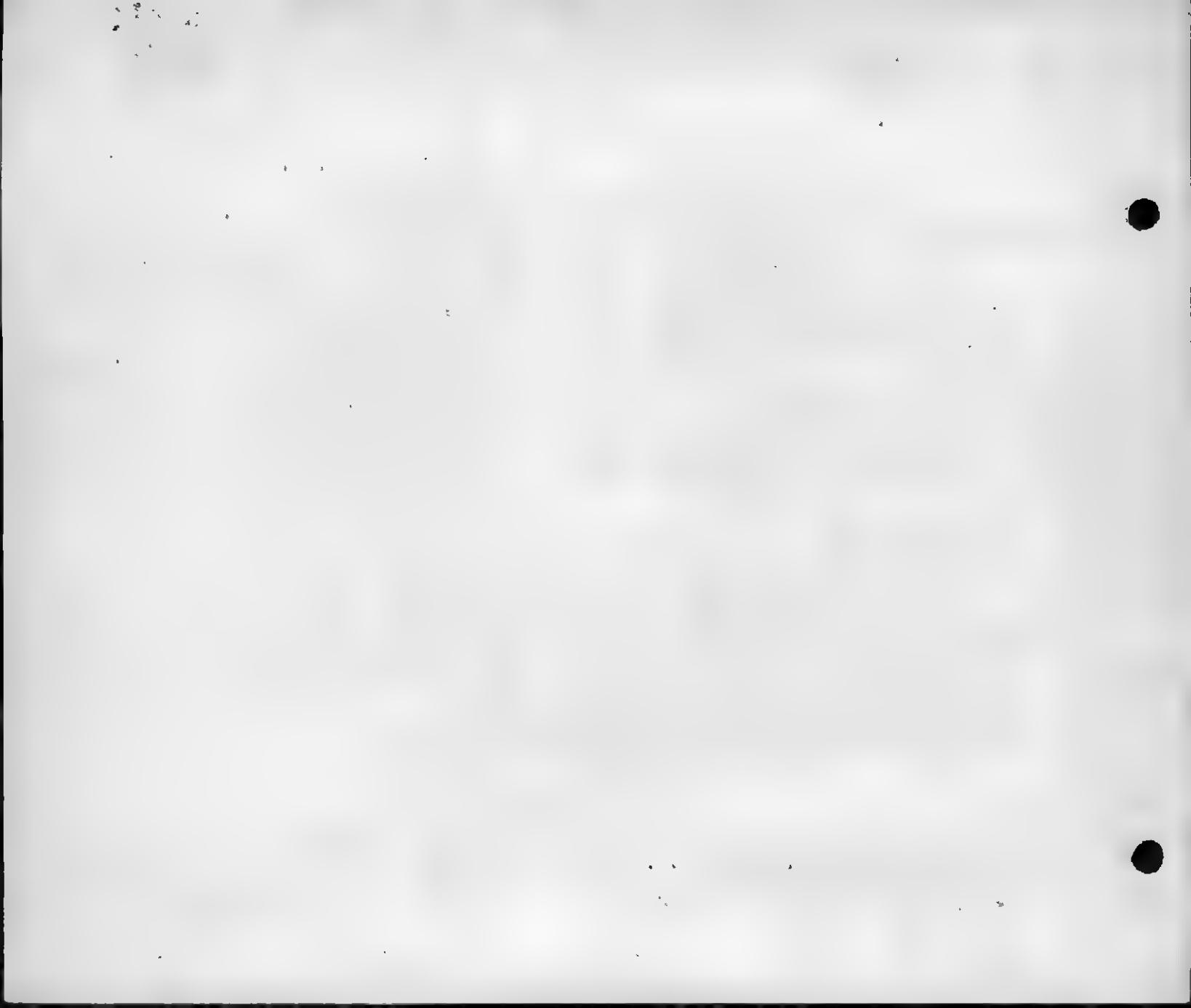
24b. REGISTRAR'S SIGNATURE

James L. Chemin

Arlington, Va.

JUL 29 '60

Albert S. Thomas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director,
page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

08411

8436

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hollywood		c. LENGTH OF STAY IN lb 18 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hollywood		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Joseph	Middle Ignatius	Last Habig	4. DATE OF DEATH July 3, 1960	Month July	Day 3	Year 1960	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 5, 1882		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing		10b. KIND OF BUSINESS OR INDUSTRY Civil Service		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Joseph Damien Habig				14. MOTHER'S MAIDEN NAME Mary Stegmier					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mary Viola Habig		Address Hollywood, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis									
332 X DUE TO Arteriosclerosis									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Perforated vascular disease of lower extremities									
INTERVAL BETWEEN ONSET AND DEATH 3 days									
10 years									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) June 30, 1960, to July 3, 1960, that (I) (we) last saw the deceased alive on July 19, 1960, and that death occurred at 2 A.M., from the causes and on the date stated above						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above									
22a. SIGNATURE Julian S. Lane M. D.		22b. M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. PHYSICIAN'S NAME (Type) Julian S. Lane M. D.		22d. ADDRESS Lexington Park, Maryland			
23a. BURIAL/CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF 7/5/60		23c. NAME OF CEMETERY OR CREMATORIAL St. John's		23d. LOCATION (City, town, or county) (State) Hollywood, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtown, Maryland		25a. REC'D BY REGISTRAR DATE JUL 6 '60		25b. REGISTRAR'S SIGNATURE Charles L. Kline			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8437

CERTIFICATE OF DEATH

08412

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Marys		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park		c. LENGTH OF STAY IN 1b Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park		d. STREET ADDRESS Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Daniel	First	Middle	Last	4. DATE OF DEATH July 10	Month	Day	Year 1960
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 18, 1879	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Sea Food		11. BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Lee				14. MOTHER'S MAIDEN NAME Zora Talton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO -----		17. INFORMANT J. Jerome Lee - Lexington Pk. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		coronary thrombosis 450-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) due to chronic myocarditis (c)					
INTERVAL BETWEEN ONSET AND DEATH 2 days		14 hr.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 9, 1960 to July 11, 1960 that I last saw the deceased alive on July 11, 1960 , and that death occurred at 6 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W.H. Patrick		ADDRESS (Street, city or town, state) Lexington Park, Md.					
PHYSICIAN'S NAME (Type) Wm. H. Patrick, MD		DATE SIGNED 7-12-60					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/13/60		22c. NAME OF CEMETERY OR CREMATORIUM St. Peters Cem.		22d. LOCATION (City, town, or county) Ridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 19 '60		24b. REGISTRAR'S SIGNATURE Clarence S. Krause	

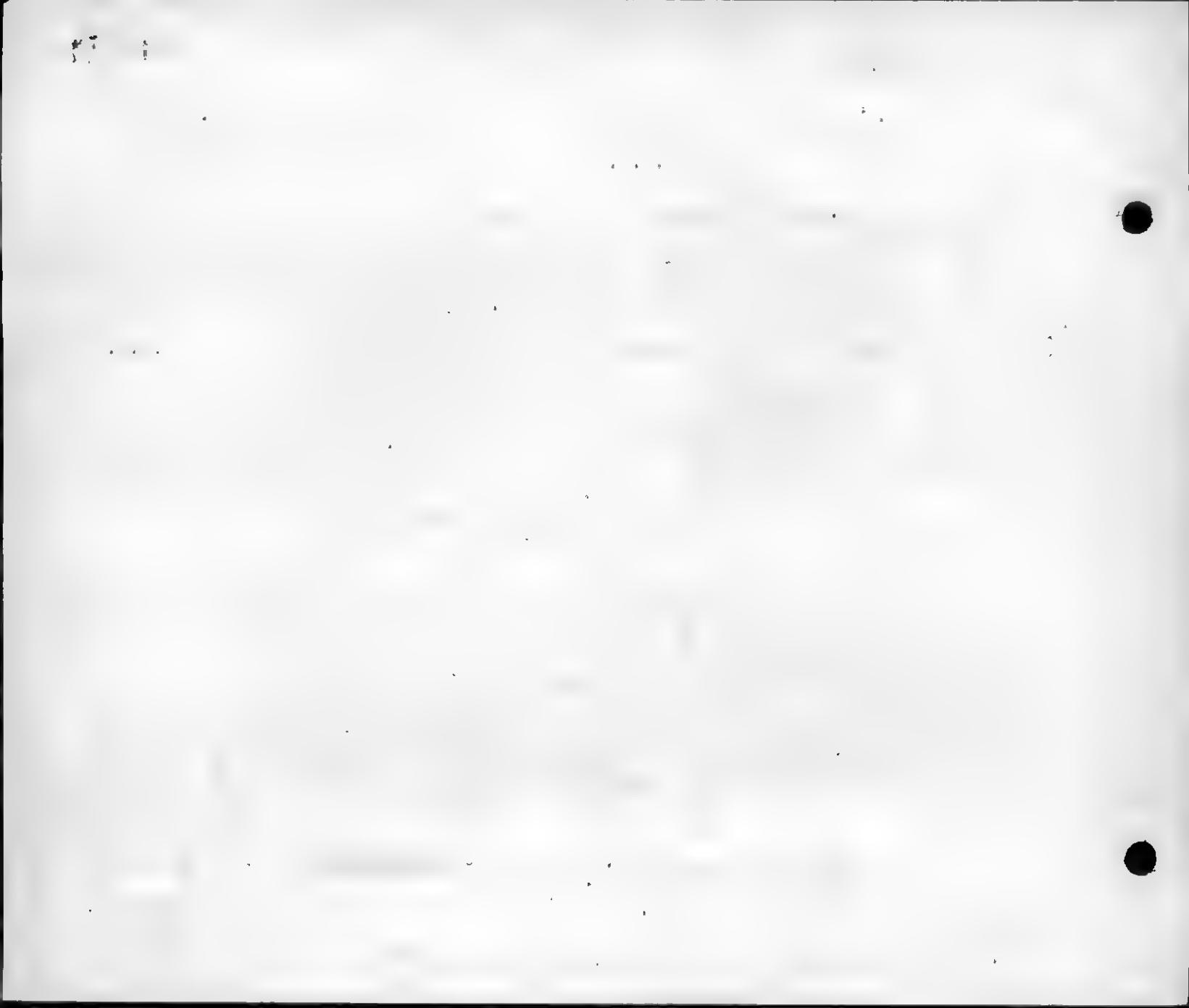
at

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08418

8427		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY St. Mary's					2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b D.O.A.			b. COUNTY St. Mary's						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Loveville						
d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First Paul	Middle B	Last Long	4. DATE OF DEATH July 8, 1960	Month July	Day 8	Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 26, 1889		9. AGE (In years lost birthday) yrs 70 yrs			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Bernard Long					14. MOTHER'S MAIDEN NAME Molly Tippett						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 6/26/18					16. SOCIAL SECURITY NO. 217-32-1942		17. INFORMANT Mrs Theodoras F. Long Loveville, Maryland			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) + (4 X) DUE TO coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO The embolic fibril (c)					INTERVAL BETWEEN ONSET AND DEATH						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Leonardtown		20f. (City or town) Loveville		(County) (State)			
21. I certify that (I) (his hospital) attended the deceased from March 1960 to July 1960 , 19____, that (I) (we) last saw the deceased alive on March 1960 and that death occurred at Leonardtown , M. from the causes and on the date stated above					22b. DATE SIGNED						
22a. SIGNATURE Michael Barbarich					M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) Michael Barbarich M. D.					22d. ADDRESS Leonardtown						
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 7/11/60		23c. NAME OF CEMETERY OR CREMATORIUM St. Joseph's			23d. LOCATION (City, town or county) (State) Morganza, Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley					ADDRESS Leonardtown, Maryland		25a. REC'D BY REGISTRAR DATE JUL 11 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8428

08414

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
ST. MARY'S		MARYLAND		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY Charles	
LEONARDTOWN		1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
ST. MARY'S Hospital		Wicomico		YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
Thomas		L.		Long	JULY 17 1960
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (in years lost birthday) yrs.
MALE		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	April 3, 1880	80
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Merchant		Se Cfi		St. Mary's Co., Md	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Philip Long		Lucy Davis		U.S.A	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		220-32-5778		Mrs. Edith M. Long (Charlotte Hatch N.	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Hemorrhage			
443 X		DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Hypertension Cardiosclerotic Disease			
DUE TO		(c) Artherosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
19				20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1958 to July 1960, that (I) (we) last saw the deceased alive on 16 Jl 1960, and that death occurred at M, from the causes and on the date stated above.				22b. DATE SIGNED	
22a. SIGNATURE		M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS			
David L. Mossman		Mechanicsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL ST. MARY'S	
Burial 7-19-60				23d. LOCATION (City, town, or county) Newport Md (State)	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
		Hunt & Funeral Home, Waldorf, Md.		DATE JUL 22 '60	Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



Item 18 Film 268 8-9-MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

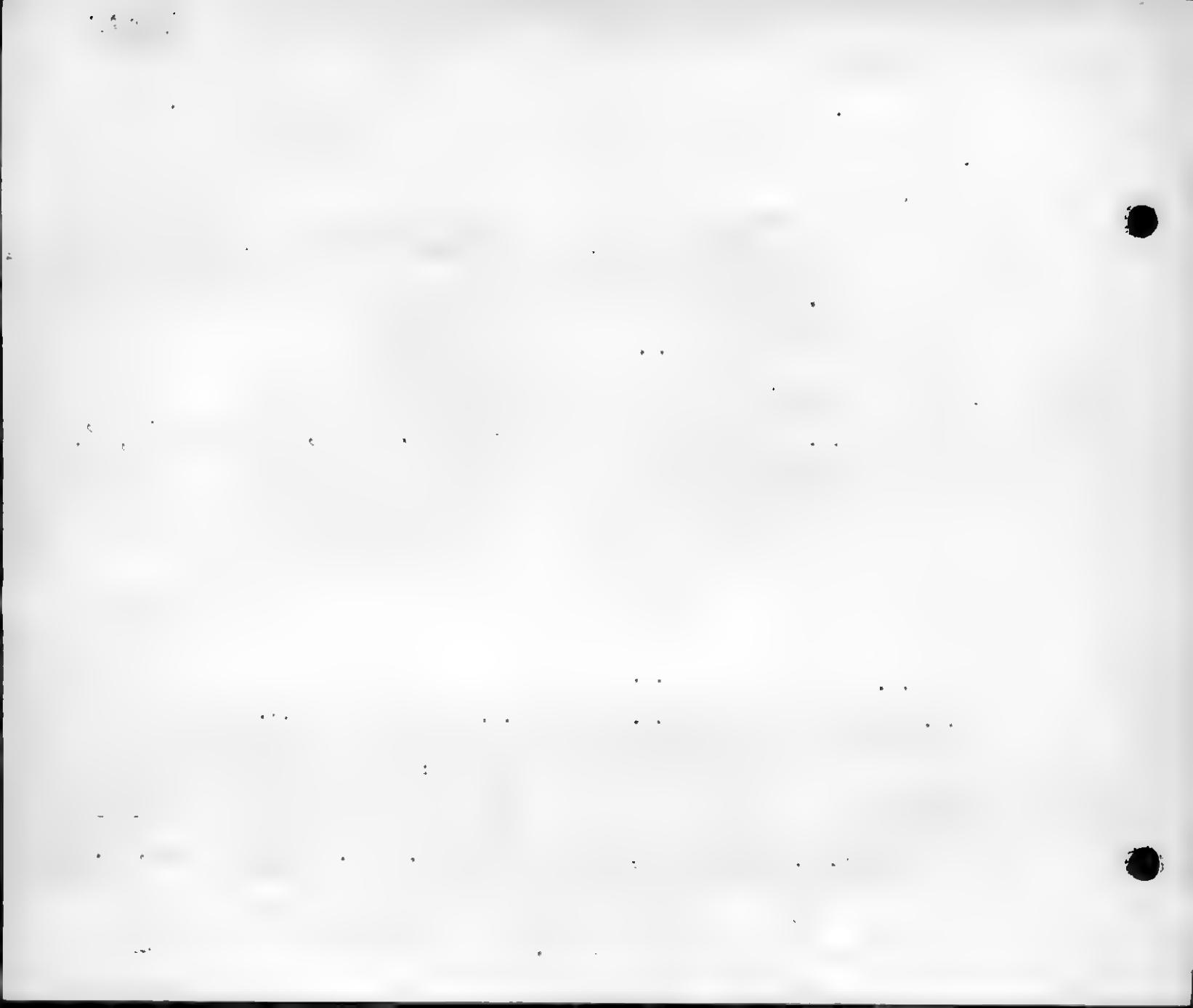
08415

8438

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Mary's				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NAS., Patuxent River				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Station Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park			
3. NAME OF DECEASED (Type or print) Angela				4. STREET ADDRESS Maryland			
5. SEX Female		6. COLOR OR RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 14 April 1960	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY N.A.		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gary Eugene OULMAN				14. MOTHER'S MAIDEN NAME Gay Jeannette SAGER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service No		16. SOCIAL SECURITY NO. N.A.		17. INFORMANT Father: Gary E. OULMAN, 48 Salamaua Court, Lexington Park, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 491X				INTERVAL BETWEEN ONSET AND DEATH 135 hr.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO				40 min			
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N.A.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) N.A.					
20c. TIME OF INJURY Month, Day, Year Hour o. m. N.A. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> N.A. While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) N.A.		20f. (City or town) N.A.	
(County) N.A.		(State) N.A.					
21. I certify that (I) (this hospital) attended the deceased from 6 July 1960 to 12 July 1960 , that (I) (we) last saw the deceased alive on 12 July 1960 , and that death occurred at 12:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE D. G. Anderson				M.D. <input type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS		22b. DATE SIGNED 7-12-60	
22c. PHYSICIAN'S NAME (Type) LT D. G. ANDERSON, MC, USN				22d. ADDRESS StaHosp., NAS., Patuxent River, Md.			
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/18/60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) Arlington, Va.	
(State)							
24. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE JUL 19 '60	
						25b. REGISTRAR'S SIGNATURE Clara L. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

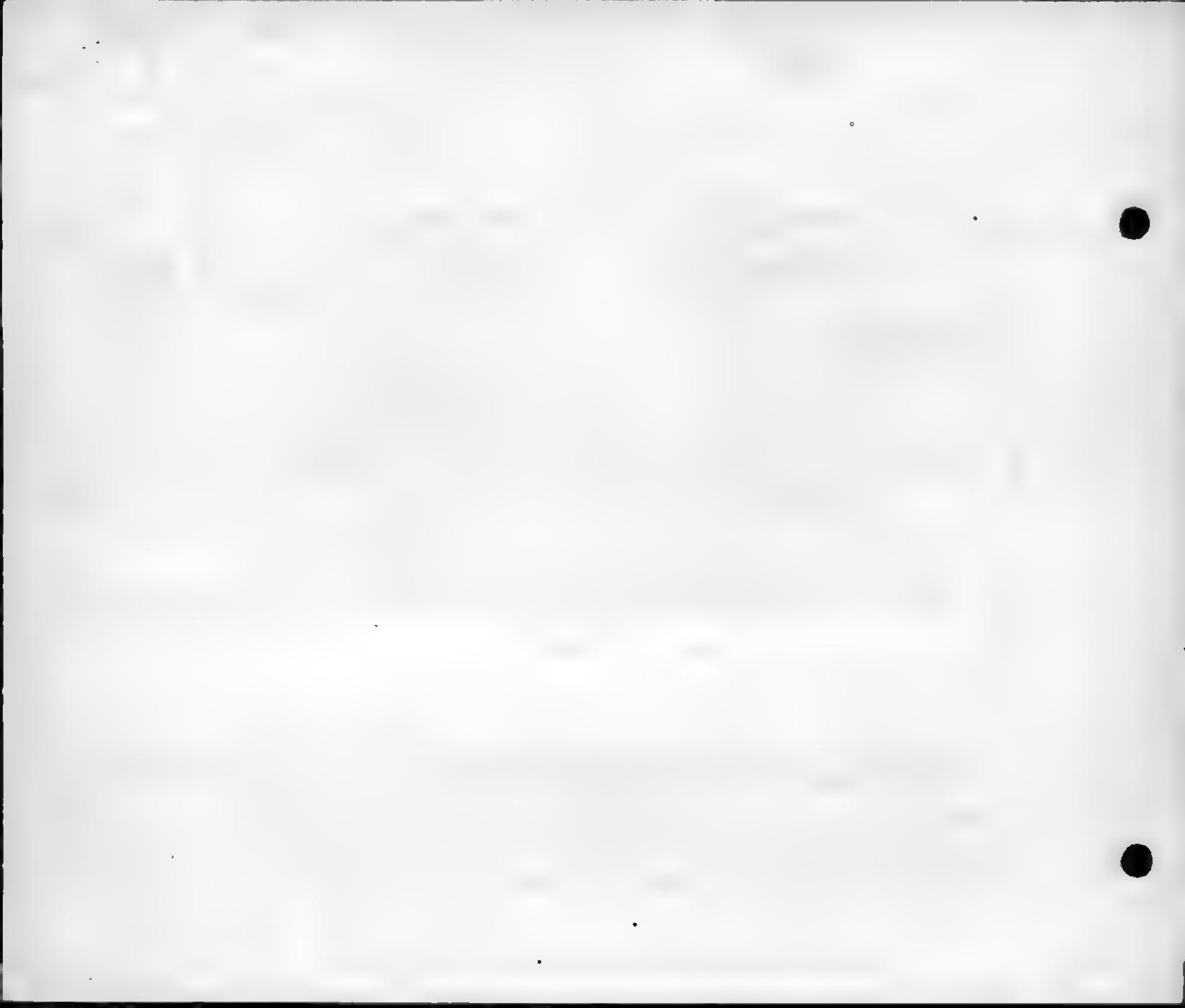
8429

CERTIFICATE OF DEATH

08416

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Marys		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE New York		b. COUNTY Monroe			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 5 dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rochester					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hospital		d. STREET ADDRESS 476 Emerson St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Harris Brooks Pettet		First Harris	Middle Brooks	Last Pettet	4. DATE OF DEATH July 3	Month July	Day 3	Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9/26/1881	9. AGE (In years last birthday) 78 yrs	IF UNDER 1 YEAR Months 9	IF UNDER 24 HRS Days 6	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glass blower		10b. KIND OF BUSINESS OR INDUSTRY Glass		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Mark Pettit		14. MOTHER'S MAIDEN NAME Ella Hann							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. 104 07 2803		17. INFORMANT Adeline Whyte		Address 996 Denise Rd. Rochester, N.Y.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 423.1 DUE TO Coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH 27 days.							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO 423.1 Part II. Other significant conditions contributing to death but not related to the terminal disease condition given in Part I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Edith M.		20f. (City or town) Roxbury		(County) Lexington Park	(State) Maryland
21. I certify that I attended the deceased from 6-29 , 19 62 , to 7-3 , 19 62 , that I last saw the deceased alive on 6-29-62 , and that death occurred at Edith M. from the causes and on the date stated above. ACTUAL SIGNATURE W.H. Patrick M.D. ADDRESS (Street, city or town, state) Roxbury, Lexington Park, Maryland DATE SIGNED 7-3-62									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/3/60		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Hope Cemetery		22d. LOCATION (City, town, or county) Rochester, N.Y.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		ADDRESS		24a. REC'D BY REGISTRAR Arthur S. Turner		24b. REGISTRAR'S SIGNATURE Arthur S. Turner			
DATE JUL 7 '60				DATE JUL 7 '60					



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

FOR STATE
HEALTH DEPT.

8439

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08417

1. PLACE OF DEATH

a. COUNTY

St. Mary's

b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Compton

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

MARYLAND

c. LENGTH OF STAY IN lb

2 hours

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

b. STATE

Maryland

b. COUNTY

St. Mary's

c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

X Leonardtown, Md.

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

Joseph

H.

Price

Male

Colored

WIDOWED

DIVORCED

8. DATE OF BIRTH

July

19

19 60

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Dish washer in Restaurant

13. FATHER'S NAME

Clements, Md.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or grade of service)

Yes

W.W. 2

16. SOCIAL SECURITY NO.

17. INFORMANT

Alice Buchanan

Address

Mrs. Alice Buchanan

Leonardtown, Md.

INTERVAL BETWEEN
ONSET AND DEATH

immed.

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

Could not swim.

Went swimming in heavy winter clothes, had been drinking.

20c. TIME OF INJURY Month, Day, Year
8.30 Hour
p.m. 7/19/1960 at work at work

20d. INJURY OCCURRED

White

Not White

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(County)

(State)

Breton Bay

Compton, St. Mary's, Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL
SIGNATURE

Ward Boyd

M.D.

DATE SIGNED

EXAMINER'S
NAME (Type)

William D. Boyd

7/20/1960

ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

(State)

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or country)

(State)

Burial
23. FUNERAL DIRECTOR

July 22, 1960

St. Aloysius

Leonardtown, Maryland

ADDRESS

W. Clarke Mattingley, Leonardtown, Md.

24a. REC'D BY REGISTRAR

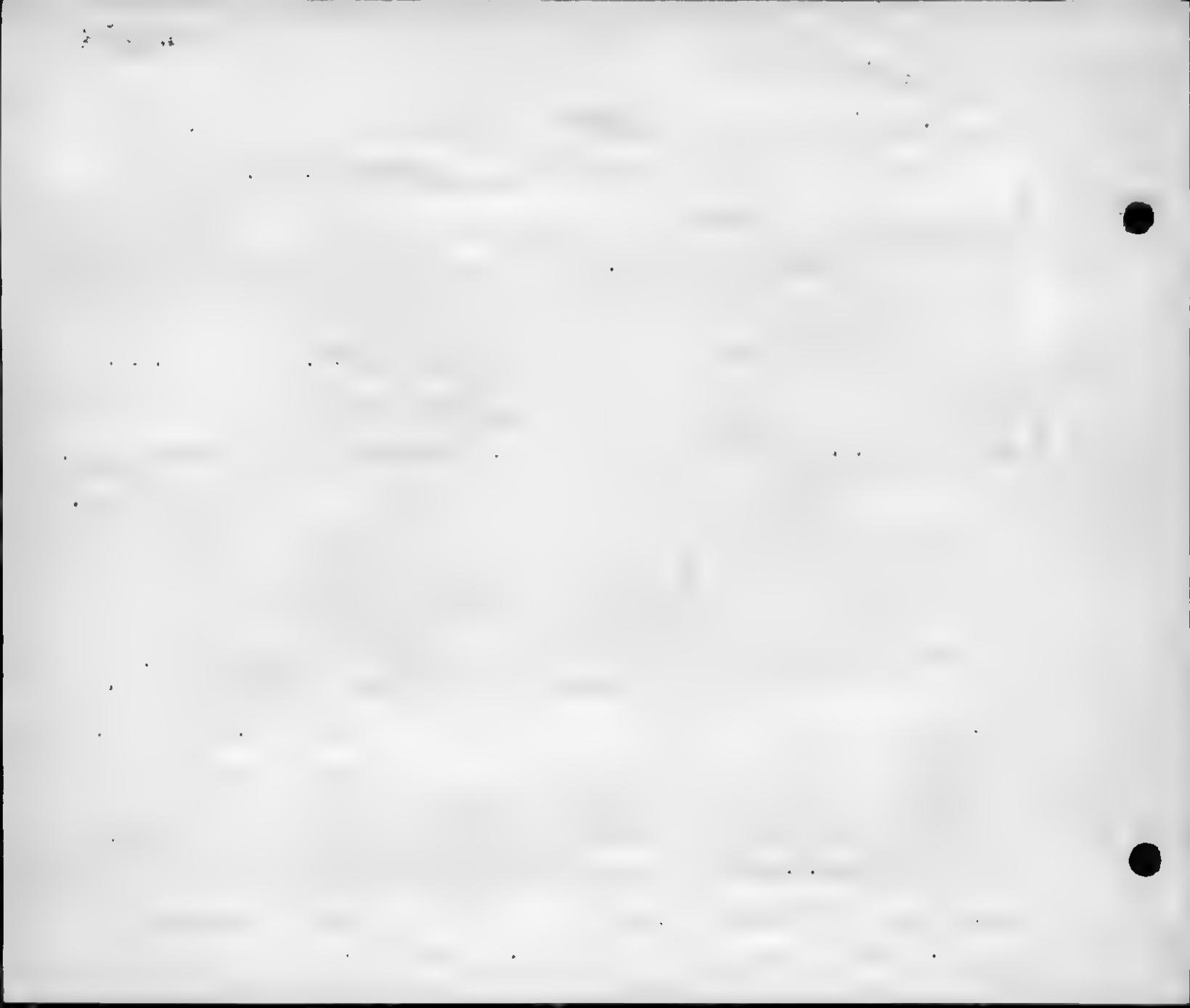
DAUL 22 '60

24b. REGISTRAR'S SIGNATURE

Arthur L. Krause

TO DEATH CERTIFICATES: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AT 5ME
5M 7/59



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

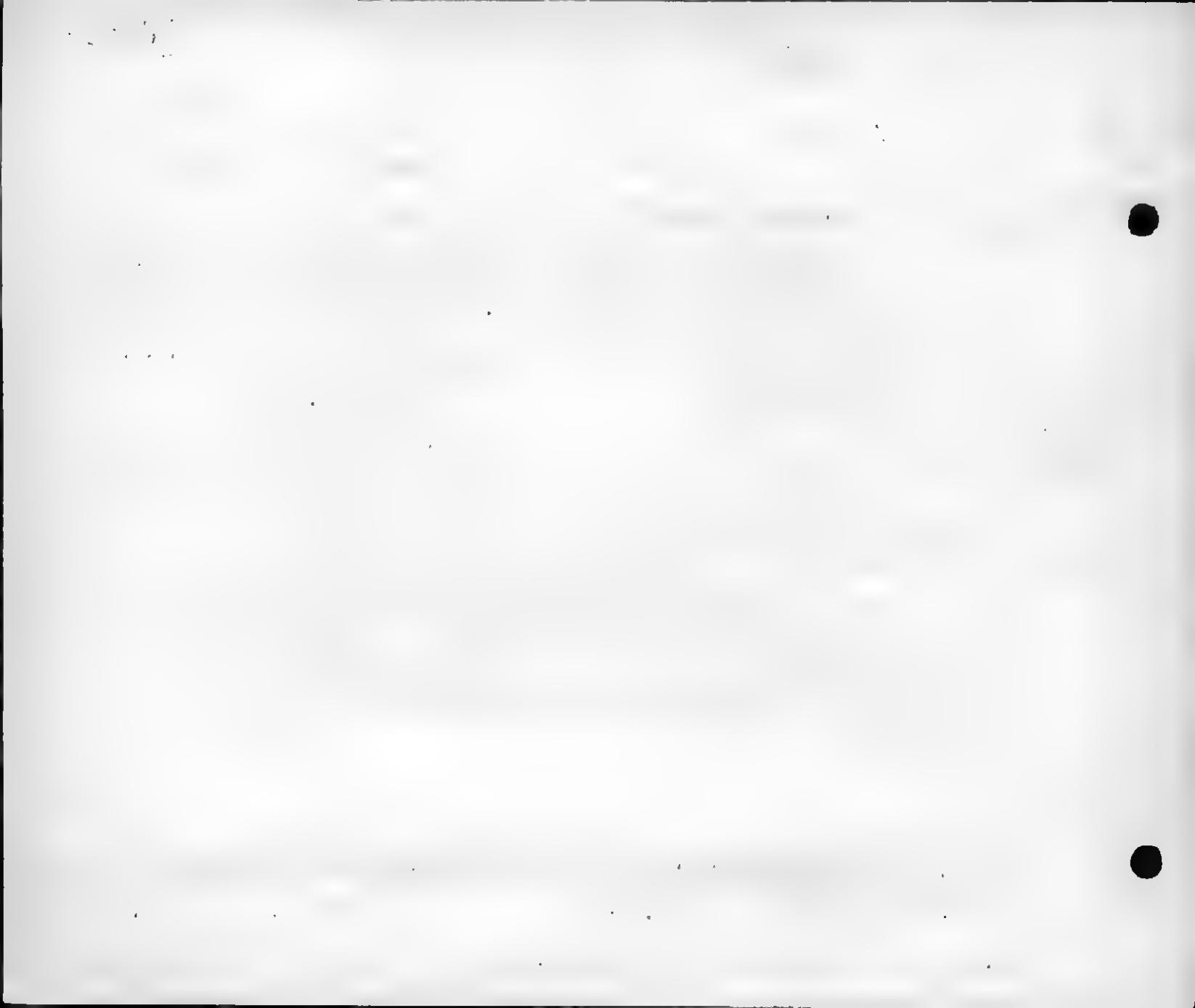
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8430

CERTIFICATE OF DEATH

118418

1. PLACE OF DEATH a. COUNTY St. Mary's		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN lb 7 days		2. USUAL RESIDENCE (Where deceased lived. If instit or Residence before admission) a. STATE Maryland		b. COUNTY Charles					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hospital		f. STREET ADDRESS Rural Bryantown		g. DATE OF DEATH July 16, 1960		h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Eleanor		First Susan		Middle Quade		Last		Month	Day	Year			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 13, 1925	9. AGE (In years lost birthday) 35 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. FATHER'S NAME Joseph Ashby Quade	14. MOTHER'S MAIDEN NAME Nellie E. Farrell	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT Mrs Nellie E. Quade Hughsville, Maryland	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X DUE TO Cancer of Cervix INTERVAL BETWEEN ONSET AND DEATH 24 m. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Saylorsburg, Pa. (County) Lycoming Co. (State) Penn.			
21. I certify that (I) (this hospital) attended the deceased from Saylorsburg, Pa. to July 16, 1960 that (I) (we) last saw the deceased alive on July 15, 1960 and that death occurred at 3 P.M. from the causes and on the date stated above											22b. DATE SIGNED		
22a. SIGNATURE Leon Berbue M. D.		22c. PHYSICIAN'S NAME (Type) Leon Berbue M. D.		22d. ADDRESS Mechanicsville, Maryland		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL/CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 7/19/60		23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's		23d. LOCATION (City, town, or county) Bryantown, Md.		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland		ADDRESS		25a. REC'D BY REGISTRAR C. L. Evans		25b. REGISTRAR'S SIGNATURE C. L. Evans							





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8440 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08419

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia		b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Park Hall		c. LENGTH OF STAY IN 1b 12 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington		d. STREET ADDRESS 225 North Jackson			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Ellen	Middle Younger	Last Roche	4. DATE OF DEATH July 9, 1960	Month July	Doy 9	Year 1960	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 14, 1908	9. AGE (In years from birthday) 51 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Hours 0	IF UNDER 24 HRS Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary-Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Attorney		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John J. Younger		14. MOTHER'S MAIDEN NAME Minnie Clayton North							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 573-18-9059		17. INFORMANT William W. Roche		Address 245 N. Jackson St., Arlington			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO inferred									
Conditions, if any, which gave rise to immediate cause (b) DUE TO 									
DUE TO (c) 									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Arlington		(County) 	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>William D. Boyd</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							DATE SIGNED 7/9/60
EXAMINER'S NAME (Type) William D. Boyd M. D.		22b. DATE THEREOF 7.11.60		22c. NAME OF CEMETERY OR CREMATORIAL Columbia Gardens Cem.		22d. LOCATION (City, town, or county) Arlington, Virginia			
22e. BURIAL, CRETATION OR REMOVAL (Specify) Burial		22f. ADDRESS Arlington Funeral Home 1941 N. Fairfax Drive		24a. REC'D BY REGISTRAR Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mac J. Krome</i>		ADDRESS Arlington, Virginia		DATE JUL 11 '60					
VS. AT 15MS 5M 2/57									

972

493

494

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8431

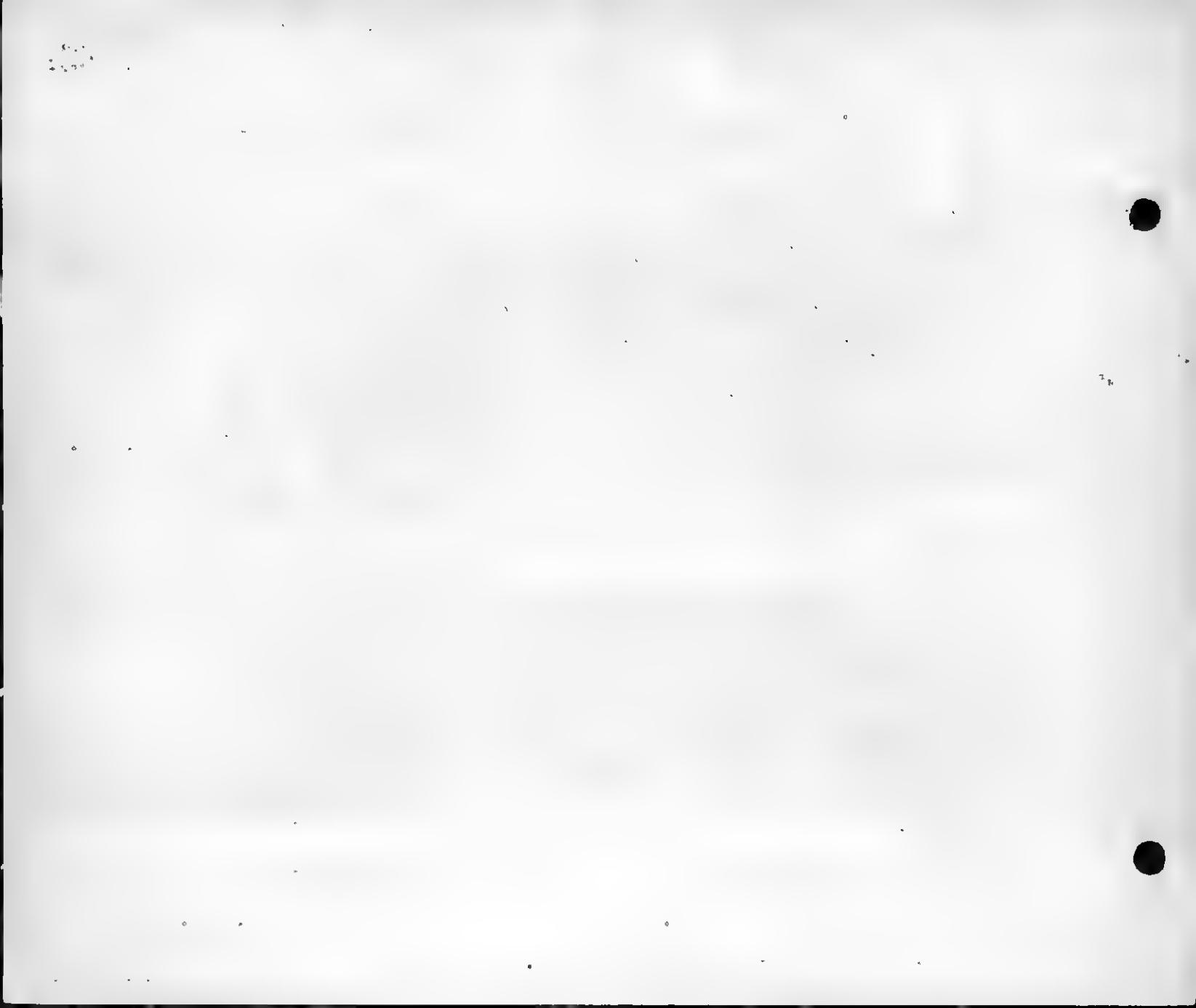
CERTIFICATE OF DEATH

08420

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Marys		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) California	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hospital		e. STREET ADDRESS Rural	
3. NAME OF DECEASED (Type or print) Nellie		First Estelle	Middle Sunderland
4. DATE OF DEATH July 12 1960		Last July	Month 12
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
			8. DATE OF BIRTH 11/17/1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John W. Tucker	
14. MOTHER'S MAIDEN NAME Mary Virginia DeVeaux		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. (If yes, give name or dates of service) -----		17. INFORMANT James C. Sunderland -California, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO Hypertension Cerebral embolism Cerebral infarction	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 10 years 10 years 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ PM, from the causes and on the date stated above. ACTUAL DATE OF DEATH W.H. Patrick M.D.		ADDRESS (Street, city or town, state) Lexington Park, Md. DATE SIGNED 7/13/60	
PHYSICIAN'S NAME (Type) Wm. H. Patrick, MD		Lexington, Park, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/15/60	
22c. NAME OF CEMETERY OR CREMATORIUM St. Johns Cemetery		22d. LOCATION (City, town, or county) (State) Hollywood, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		24a. REG'D BY REGISTRAR JUL 19 1960	
ADDRESS Leonardtown, Md.		24b. REGISTRAR'S SIGNATURE John J. Moore	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8441

CERTIFICATE OF DEATH

08421

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY St. Mary's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Avenue		c. LENGTH OF STAY IN lb 53 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Avenue		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First James	Middle Olyde	Last Utz	4. DATE OF DEATH Month July	Month 6.	Day 19	Year 60
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH May 15, 1889	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail carrier & Trucker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Madison, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Nelson Utz				14. MOTHER'S MAIDEN NAME Annie Utz				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 578 24 5561	17. INFORMANT Sally W. Utz	Address Avenue, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 434.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				Acute dilatation of heart				
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan 12 1960 to July 6 1960 , that (I) (we) last saw the deceased alive on Jul 7 1960 , and that death occurred at 4 AM , from the causes and on the date stated above.								
22a. SIGNATURE Charles Greenwell		M.D.		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Charles Greenwell M.D.		22d. ADDRESS Leonardtown, Maryland						
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 9, 1960		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill		23d. LOCATION (City, town, or county) Madison (State) Va.		
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtown, Maryland.		25a. REC'D BY REGISTRAR JUL 9 1960		25b. REGISTRAR'S SIGNATURE C. J. Smith Jr.		

4

1. *Leucostoma galacto-*
2. *Leucostoma galacto-*
3. *Leucostoma galacto-*

1
FOR STATE
HEALTH DEPT.



4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal.

V.S. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8442

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08422

1. PLACE OF DEATH

a. COUNTY

Saint Mary's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL - New Market, Md.

c. LENGTH OF STAY IN lb

1 yr.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Maryland State Highway #5

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Mitchell

Wayne

WARD

5. SEX

6. COLOR OR RACE

Male

Caucasian

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

B. DATE OF BIRTH

14 April 1940

9. AGE (In years
last birthday)

20 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Aviation Elec.

10b. KIND OF BUSINESS OR INDUSTRY

U.S. Navy

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Archie Leon WARD

14. MOTHER'S MAIDEN NAME

Ruth (n) GORE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? [Yes, no, or unknown] (If yes, give rank or date of service)

Yes 10-1-58 to 7-11-60 240-64-1318

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

FRACTURED SKULL

INTERVAL BETWEEN
ONSET AND DEATH

Immediate

16X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

None

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Passenger in Private Automobile and was struck by on-coming truck.

20c. TIME OF INJURY Month, Day, Year

Hour a.m. 1:15 7-11 1960

20d. INJURY OCCURRED

White Not White
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

Rt. 5, 1 mile So.

20f. (City or town)

New Market, St. Mary's, Md.

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry and in my opinion

death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

7-11-60

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

W.M. D. BOYD

Address (Street, city, town, or county)

22e. BURIAL, CREMATION,
REMOVAL (Specify)

22f. DATE THEREOF

22g. NAME OF CEMETERY OR CREMATORI

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR

ADDRESS

24e. REC'D BY REGISTRAR

24f. REGISTRAR'S SIGNATURE

P.B. Robinson - Leonardtown, Md.

JUL 19 '60

DATE

Orline S. Kraus

Signature

SSMII

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